NAADI Healthcare
Vascular and Interventional Specialists

Interventional Pain Referral Form

Patient Name: ____ **DOB:**____________

Patient Address:____

____

Patient Phone: ____

Patient Insurance: ____

Referring Physician: ____

Phone Number: ____

Fax Number: ____

Prior Imaging:____

RADIOFREQUENCY ABLATION CONSULT
[ ] Cervical [ ] Thoracic [ ] Lumbar

KYPHOPLASTY CONSULT
[ ] Lumbar _____________________ [ ] Thoracic_____________________

SPINAL CORD STIMULATOR
[ ] Consult

GENICULATE ARTERY EMBOLIZATION (GAE) CONSULT
[ ] Left Knee [ ] Right Knee

OTHER CONSULT / OR NOTES

[ ] ____

____

____

____

____

Demographic Sheet, Recent H&P, Diagnostic Images, Labs (including coagulation), Medication List, Insurance Information

P: (209) 788-8180 F: (209) 783-0036 145 Trevino Ave Manteca, CA 95337

Thank You For The Opportunity To Participate In Your Patient's Health Care